STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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METHODS FOR PAYMENT OF REASONABLE COSTS - INPATIENT HOSPITAL SERVICES

2. Rural Hospitals

If a hospital is located in a rural area (i.e., not "urbanized") as defined for the U.S. census, capital reimbursement will be limited if occupancy in the hospital is less than 60% during the hospital's fiscal year. For hospitals with occupancy less than 60%, the Medicaid reimbursement for capital will be:

$$\frac{\textit{Occupancy}}{0.6} \times \textit{Medicaid Share of Capital}$$

If occupancy is at least 60%, the Medicaid reimbursement for capital will be 100% of the Medicaid share of capital.

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3. Other Hospitals

If a hospital is not eligible to be a sole community provider and is not located in a rural area, capital reimbursement will be limited if occupancy in the hospital is less than 75% during the hospital's fiscal year. For hospitals with occupancy less than 75%, the Medicaid reimbursement for capital will be:

$$\frac{\text{Occupancy}}{0.75} \times \textit{Medicaid Share of Capital}$$

If occupancy is at least 75%, the Medicaid reimbursement for capital will be 100% of the Medicaid share of capital.

4. Hospitals Outside of Michigan

Medical/surgical hospitals not located in Michigan and enrolled in the Michigan Medicaid program receive a per case add-on amount to cover capital cost.

Freestanding psychiatric hospitals and distinct part psychiatric units of hospitals not located in Michigan and enrolled in the Michigan Medicaid program receive a per day add-on amount to cover capital cost.

The add-on amounts are an estimate of the statewide average paid to hospitals located in Michigan. Capital payments to out-of-state hospitals are not cost settled.

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J. Direct Medical Education

10/01/95 | 1. Existing Graduate Medical Education Programs

The manner of reimbursement and adjustment for direct medical education costs is the same as that for capital cost.

The amount of reimbursement to a hospital for direct medical education is the Medicaid share of an amount equal to:

(GME FTE's X 1989 Cost per FTE X Inflation) + Other DME

GME FTE's is the number of full-time equivalent interns and residents in the hospital's graduate medical education program using the Medicare definitions of full-time equivalence.

1989 Costs per FTE is the allowable costs per FTE for graduate medical education under Medicare Principles of Reimbursement during hospital fiscal years ending in between October 1, 1988 and September 30, 1989.

Inflation from 1989 for hospital fiscal years beginning between October 1, 1993 and September 30, 1994 use the same index as that for the DRG price (see Part III, Section C).

Other DME is direct medical education costs other than for graduate medical education.

The 1989 Costs per FTE are limited to the 80th percentile of allowable costs per FTE for graduate medical education. For purposes of applying the GME limit, affiliated hospitals operating a single GME program will have FTE's and costs combined. If below the limit, hospital specific FTE rates are paid.

The 80th percentile is determined by listing the hospitals in ascending order of costs per GME FTE. The hospital's cost per GME FTE at the point where 80% of the total GME FTEs in the period are listed becomes the limit.

2. New Graduate Medical Education Programs

10/01/95 | If a hospital that has never had a graduate medical education program (and therefore has no base year per FTE rate) establishes a new graduate medical education program, the hospital's GME cost per FTE base will be set at the weighted average per FTE rate for all hospitals with GME programs. This rate will be used until the per FTE amount is rebased to a period in which the hospital has graduate medical education costs.

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10/01/95 3. Inflation for Graduate Medical Education Programs

In determining the 80th percentile, each hospital's costs per FTE were standardized to approximate a hospital with FYE 9/30/89. The applied by fiscal year end are:

FTE	Wage & Benefit Inflation to 88/89
10/31/88	1.049
12/31/88	1.041
3/31/89	1.027
4/30/89	1.023
5/31/89	1.012
6/30/89	1.013
8/31/89	1.000
9/30/89	1.000

10/01/95

10/01/95

The inflation updates for periods ending after October 1, 1995 are:

FTE	Inflation
1990	1.050
1991	1.047
1992	1.033
1993	1.031
1994	1.025
1995	1.031
1996	1.035

10/01/95

Hospitals not located in Michigan are not reimbursed for direct medical education cost.

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IV. Appeals

Hospitals may review and/or appeal the components used to determine payment as well as the amount of that payment.

Beginning with rates effective October 1, 1990, hospitals will be allowed 30 days to review new data used to set rates. Hospitals will have 30 days to notify the DSS of any errors in the new data and to provide any and all supporting documentation to support their contention that the data is incomplete or inaccurate. The DSS will have 60 days after receipt of a challenge to the data to accept all or part of the correction, or to deny the hospital's request. If the hospital is not satisfied with the DSS decision, further action may be taken though the administrative appeals process. In any event, once data has been accepted by the hospital or resolved through the appeals process, no subsequent challenge to the data will be accepted by the DSS.

Appeals of price components must be received within 30 calendar days of the date of notification of a change in pricing components or of a notice of final settlement.

Appeal requests will be granted to remedy instances where incorrect data were used in the calculation of DRG prices or per diem rates or for other items deemed by the appeals panel or the administrative law judge to be within the scope of the jurisdiction as granted by the Department director.

The appeals process for pricing components includes the following steps:

1. An administrative review conducted by Medicaid Program staff that may include a meeting with representatives of the appealing hospital.

2. If the decision reached in administrative review is not acceptable to the hospital, further review by an appeal panel may be requested. The appeal panel consists of a hospital provider member, an independent member, and a representative of the Medicaid Program.

   Prior to an appeal before the appeal panel, hospitals may elect to instead present their appeal to an administrative law judge employed by the DSS. In either event, the decision of the appeal panel or law judge is forwarded to the director of the Department of Social Services who may accept, modify, or reverse the appeal panel's or the administrative law judge's finding. Both parties are notified of the decision sent to the director and have an opportunity send the director a written statement taking exception to the recommended decision.

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3. The decision by the Director shall be binding unless the hospital wishes to appeal the decision to a court of appropriate jurisdiction.

To appeal the payment amount for individual claims, a hospital may submit additional documentation to the MSA for consideration if full or partial program payment is denied (admissions, readmissions, transfers, outliers). If a denial occurs through the prepayment editing process, a new invoice or claim adjustment may be submitted with the appropriate documentation, in accordance with established billing procedures. If a denial occurs through the utilization review process, appropriate additional documentation relative to the case may be submitted to the MSA, Bureau of Health Services Review. Adjudication through provisions of the Administrative Procedures Act is available to the hospital, if resolution is not reached at the first step.

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10-1-91 | V. Deleted

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- When a new grouper program is introduced by Medicare, the DSS will make reasonable efforts to implement the new grouper with recalibrated weights as soon as possible. The target date for implementing each new grouper will be six months after Medicare's release. If the state-wide case mix index changes by more than 2%, each hospital's DRG price will be recomputed.

- The disproportionate share adjustor formula multipliers will be modified annually on a prospective basis to distribute approximately $38 million to DRG reimbursed hospitals and $7 million to per diem reimbursed providers. The modification will be based on estimated rate changes, current distribution of services, indigent volume data.

- The special $18 newborn payment will not be paid for dates of service after October 1, 1991.

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Attachment 4.19-A
Appendix A

DRG Grouper version 11.0, effective for admissions on and after October 1, 1994.

List of diagnosis related groups (DRGs), relative weighing factors, arithmetic mean length of stay, and length of stay. Outlier cutoff points used in the prospective payment system for the Michigan Medicaid Program.

DRG	MDC	DESCRIPTION	RELATIVE WEIGHT	AVERAGE LOS	Outlier Thresholds LOW DAY	HIGH DAY
1	1 SURG	CRANIOTOMY AGE > 17 EXCEPT FOR TRAUMA	4.6740	13.42	1	44
2	1 SURG	CRANIOTOMY FOR TRAUMA AGE > 17	6.1856	16.60	1	48
3	1 SURG	CRANIOTOMY AGE 0-17	2.7387	9.17	1	40
4	1 SURG	SPINAL PROCEDURES	2.9337	11.69	2	42
5	1 SURG	EXTRACRANIAL VASCULAR PROCEDURES	2.4510	6.23	1	22
6	1 SURG	CARPAL TUNNEL RELEASE	0.7202	1.50	1	7
7	1 SURG	PERIPHA & CRANIAL NERVE & OTHER NERV STYST PROC W CC	3.2396	12.89	1	43
8	1 SURG	PERIPHA & CRANIAL NERVE & OTHER NERV STYST PROC W/O CC	1.2010	3.12	1	16
9	1 MED	SPINAL DISORDERS & INJURIES	1.9220	10.18	1	40
10	1 MED	NERVOUS SYSTEM NEOPLASMS W CC	1.8697	9.12	1	26
11	1 MED	NERVOUS SYSTEM NEOPLASMS W/O CC	1.4017	6.76	1	33
12	1 MED	DEGENERATIVE NERVOUS SYSTEM DISORDERS	1.7386	7.27	1	27
13	1 MED	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA	1.2290	7.12	1	19
14	1 MED	SPECIFIC CEREBROVASCULAR DISORDERS EXCEPT TIA	2.2934	9.32	1	30
15	1 MED	TRANSIENT ISCHEMIC ATTACK & PRECEREBRAL OCCLUSIONS	1.0800	4.59	1	13
16	1 MED	NONSPECIFIC CEREBROVASCULAR DISORDERS W CC	2.1712	8.60	1	31
17	1 MED	NONSPECIFIC CEREBROVASCULAR DISORDERS W/O CC	1.1743	4.94	1	25
18	1 MED	CRANIAL & PERIPHERAL NERVE DISORDERS W CC	1.2741	6.34	1	19
19	1 MED	CRANIAL & PERIPHERAL NERVE DISORDERS W/O CC	1.1361	4.71	1	14
20	1 MED	NERVOUS SYSTEM INFECTION EXCEPT VIRAL MENINGITIS	2.4487	10.86	1	32
21	1 MED	VIRAL MENINGITIS	0.7333	3.68	1	11
22	1 MED	HYPERTENSIVE ENCEPHALOPATHY	1.4483	5.68	1	19
23	1 MED	NONTRAUMATIC STUPOR & COMA	1.3931	4.89	1	25
24	1 MED	SEIZURE & HEADACHE AGE > 17 W CC	1.2993	5.25	1	18
25	1 MED	SEIZURE & HEADACHE AGE > 17 W/O CC	0.7687	3.46	1	11
26	1 MED	SEIZURE & HEADACHE AGE 0-17	0.6532	3.01	1	9
27	1 MED	TRAUMATIC STUPOR & COMA, COMA > 1 HR	1.8780	5.73	1	38
28	1 MED	TRAUMATIC STUPOR & COMA, COMA < 1H AGE > 17 W CC	1.5162	6.36	1	29
29	1 MED	TRAUMATIC STUPOR & COMA, COMA < 1H AGE > 17 W/O CC	0.9089	4.00	1	18
30	1 MED	TRAUMATIC STUPOR & COMA, COMA < 1H AGE 0-17	0.6062	2.53	1	10
31	1 MED	CONCUSSION AGE > 17 W CC	0.7125	2.47	1	11
32	1 MED	CONCUSSION AGE > 17 W/O CC	0.6238	2.10	1	6
33	1 MED	CONCUSSION AGE 0-17	0.4066	1.49	1	4
34	1 MED	OTHER DISORDERS OF NERVOUS SYSTEM W CC	1.6263	6.38	1	24
35	1 MED	OTHER DISORDERS OF NERVOUS SYSTEM W/O CC	0.8020	3.30	1	10
36	2 SURG	RETINAL PROCEDURES	0.9604	1.97	1	7
37	2 SURG	ORBITAL PROCEDURES	1.1789	3.89	1	13
38	2 SURG	PRIMARY IRIS PROCEDURES	0.4796	1.00	1	5
39	2 SURG	LENS PROCEDURES WITH OR WITHOUT VITRECTOMY	0.8475	1.96	1	8
40	2 SURG	EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE > 17	1.0412	3.73	1	13
41	2 SURG	EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE 0-17	0.6787	2.34	1	11
42	2 SURG	INTRAOCULAR PROCEDURES EXCEPT RETINA, IRIS & LENS	0.8980	2.81	1	12

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DRG	MDC	DESCRIPTION	RELATIVE WEIGHT	AVERAGE LOS	Outlier Thresholds LOW DAY	HIGH DAY
43	2 MED	HYPHEMA	0.5564	4.48	2	10
44	2 MED	ACUTE MAJOR EYE INFECTIONS	0.5810	3.83	1	10
45	2 MED	NEUROLOGICAL EYE DISORDERS	0.9905	6.03	1	26
46	2 MED	OTHER DISORDERS OF THE EYE AGE > 17 W CC	0.9505	5.46	1	25
47	2 MED	OTHER DISORDERS OF THE EYE AGE > 17 W/O CC	0.6494	4.19	1	34
48	2 MED	OTHER DISORDERS OF THE EYE AGE 0-17	0.5910	3.50	1	14
49	3 SURG	MAJOR HEAD & NECK PROCEDURES	2.9678	8.49	1	40
50	3 SURG	SIALOADENECTOMY	0.9731	2.34	1	12
51	3 SURG	SALIVARY GLAND PROCEDURES EXCEPT SIALOADENECTOMY	0.9351	3.38	1	10
52	3 SURG	CLEFT LIP & PALATE REPAIR	0.7272	1.95	1	6
53	3 SURG	SINUS & MASTOID PROCEDURES AGE > 17	1.1363	3.65	1	13
54	3 SURG	SINUS & MASTOID PROCEDURES AGE 0-17	1.2436	4.38	1	27
55	3 SURG	MISCELLANEOUS EAR, NOSE, MOUTH & THROAT PROCEDURES	1.5226	4.48	1	24
56	3 SURG	RHINOPLASTY	1.0450	3.17	1	7
57	3 SURG	T&A PROC, EXCPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE > 17	0.8073	3.55	1	13
58	3 SURG	T&A PROC, EXCPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0-17	1.1696	4.09	1	25
59	3 SURG	TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE > 17	0.9797	3.00	1	6
60	3 SURG	TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0-17	0.8917	2.98	1	10
61	3 SURG	MYRINGOTOMY W TUBE INSERTION AGE > 17	1.3254	4.25	1	8
62	3 SURG	MYRINGOTOMY W TUBE INSERTION AGE 0-17	0.9032	3.19	1	16
63	3 SURG	OTHER EAR, NOSE, MOUTH & THROAT O.R. PROCEDURES	1.5162	4.52	1	19
64	3 MED	EAR, NOSE, MOUTH & THROAT MALIGNANCY	2.3481	11.48	1	34
65	3 MED	DYSEQUILIBRIUM	0.7848	3.71	1	12
66	3 MED	EPISTAXIS	1.0163	4.79	1	24
67	3 MED	EPIGLOTTITIS	1.2428	3.95	1	11
68	3 MED	OTITIS MEDIA & URI AGE >17 W CC	0.9119	4.56	1	17
69	3 MED	OTITIS MEDIA & URI AGE >17 W/O CC	0.6187	3.03	1	7
70	3 MED	OTITIS MEDIA & URI AGE 0-17	0.4890	2.74	1	7
71	3 MED	LARYNGOTRACHETIS	0.4747	2.29	1	6
72	3 MED	NASAL TRAUMA & DEFORMITY	0.6250	2.45	1	8
73	3 MED	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE >17	0.9313	4.28	1	13
74	3 MED	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE 0-17	0.8862	3.88	1	17
75	4 SURG	MAJOR CHEST PROCEDURES	4.2071	13.13	1	44
76	4 SURG	OTHER RESP SYSTEM O.R. PROCEDURES W CC	4.1851	15.37	2	46
77	4 SURG	OTHER RESP SYSTEM O.R. PROCEDURES W/O CC	2.3106	9.05	1	40
78	4 MED	PULMONARY EMBOLISM	2.1556	9.03	1	22
79	4 MED	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W CC	2.9394	12.08	2	38
80	4 MED	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W/O CC	1.9152	8.30	2	25
81	4 MED	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE 0-17	1.7461	7.37	1	22
82	4 MED	RESPIRATORY NEOPLASMS	2.3641	10.05	1	34
83	4 MED	MAJOR CHEST TRAUMA W CC	1.3386	5.37	1	23
84	4 MED	MAJOR CHEST TRAUMA W/O CC	0.7977	3.21	1	11
85	4 MED	PLEAURAL EFFUSION W CC	2.1382	9.97	1	37
86	4 MED	PLEAURAL EFFUSION W/O CC	1.2408	6.04	1	12
87	4 MED	PULMONARY EDEMA & RESPIRATORY FAILURE	3.1970	9.01	1	36
88	4 MED	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	1.4918	6.06	1	20
89	4 MED	SIMPLE PNEUMONIA & PLEURISY AGE >17 W CC	1.7643	7.27	1	22
90	4 MED	SIMPLE PNEUMONIA & PLEURISY AGE >17 W/O CC	1.1541	4.89	1	12
91	4 MED	SIMPLE PNEUMONIA & PLEURISY AGE 0-17	0.7656	3.74	1	10
92	4 MED	INTERSTITIAL LUNG DISEASE W CC	1.6705	6.76	1	28
93	4 MED	INTERSTITIAL LUNG DISEASE W/O CC	0.8864	4.05	1	11
94	4 MED	PNEUMOTHORAX W CC	1.5617	6.76	1	21
95	4 MED	PNEUMOTHORAX W/O CC	0.9243	4.66	1	14
96	4 MED	BRONCHITIS & ASTHMA AGE > 17 W CC	1.2849	5.35	1	15
97	4 MED	BRONCHITIS & ASTHMA AGE > 17 W/O CC	0.8531	3.71	1	10

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